Medical History Questionnaire

Name:___________________________________ Married · Single · Today's Date: _______ / ______ / ______

Address: ____ Phone: _____________________________

City:__________________________ State:________Zip Code:_____________ Work Phone: ________________________

Birth Date: _____ / _____ / _____ Social Security #:_______ / _____ / ______ Last Eye Exam:______ / _______ / ______

Occupation:____ Hobbies:____________________________________

Name of Medical Doctor:____ Dr.'s Phone: _________________________

How did you hear about us?____ Last Medical Exam: _____ / _____ / _____

Getting to know you...List any persons residing with you____

____

Medical History

Do you have any allergies to medications? · no · yes If yes, explain: ____________________________________

____

List any medications you take (including oral contraceptives, aspirin, over the counter mediation and home remedies):

____

List all major injuries, surgeries and/or hospitalizations you have had: ____

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:____

Are you pregnant and/or nursing? · no · yes

Do you wear glasses? · no · yes If yes, how old is your present pair of lenses?_____________________

Do you wear contact lenses? · no · yes If yes, how old is your present pair of lenses?___________________

Type of contact lenses: · Rigid · Soft · Extended Wear · Other Are they comfortable? · no · yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASES/CONDITIONS	NO	YES	?	RELATIONSHIP TO YOU
Blindness	·	·	·	______________________________
Cataract	·	·	·	______________________________
Crossed Eyes	·	·	·	______________________________
Glaucoma	·	·	·	______________________________
Macular Degeneration	·	·	·	______________________________
Retinal Detachment/Disease	·	·	·	______________________________
Arthritis	·	·	·	______________________________
Cancer	·	·	·	______________________________
Diabetes	·	·	·	______________________________
Heart Disease	·	·	·	______________________________
High Blood Pressure	·	·	·	______________________________
Kidney Disease	·	·	·	______________________________
Lupus	·	·	·	______________________________
Thyroid Disease	·	·	·	______________________________
Other ______________________	·	·	·	______________________________

***We make every effort at the time of service to determine your complete benefit information from your insurance carrier. Please be advised the information provided to us by your carrier is not a guarantee of coverage and will not be determined until the final claim is processed by your carrier. We provide services that are necessary based on your medical condition and the care required. We bill for those services using national standards and billing rules. Your insurance company's rules will determine how the claim is paid. If after processing the claim, the insurance carrier determines that benefits are a "non-covered" benefit or subject to deductible, the patient will be responsible for the remaining balance and notified with a copy of the Explanation of Benefits and billed at that time. _________________ Patient Initials**

** Please complete page two **